Air Conditioning Medical Exception Policy

Students are not permitted to bring air conditioners without documented medical reasons. Any student who has a medical condition or disability that necessitates air conditioning in his/her room as part of their prescribed treatment must have a Medical Request for Air Conditioning Request form completed by their Primary Care Physician, Allergist, Pulmonologist, or Ear, Nose and Throat Specialist.

Once the need is documented, it will be reviewed by Health Services. If approved, Residence Life will maintain a copy of the request on file. The student must provide the air conditioner for the University to install. Residence Life will facilitate the installation of the air conditioning unit with the facilities staff. Air conditioner installation requests submitted by students will not be approved. Window units are the only approved type of air conditioning unit. Below is a summary of the steps to complete a request. Unauthorized air conditioner units will be removed and the student will be subject to University Disciplinary actions.

Step One: Student prints out the form and completes their portion of the form.

Step Two: Student takes form to their appropriate licensed health care professional to complete. Doctor notes, prescriptions from a physician, and other documents will not be accepted. A physician must complete the form in its entirety.

Step Three: Student delivers the completed Medical Request for Air Conditioning form to the Office of Residence Life located in the Mac Mahon Student Center, 5th Floor.

Step Four: After your information is reviewed, you will be notified of the status of your request. If the request is approved, you will receive additional information via your University email address.
Medical Request for Air Conditioning

This form must be completed in full and submitted for review to the Office of Residence Life. There are three sections to be completed: Student section, Physician section, and Health Services & Residence Life section. Incomplete forms will not be considered.

Student completes this section:

Today's Date: ________________  ID#: __________  Birth date: ________________
First Name: ____________________  Last Name: ____________________
Cell Phone Number: ________________

Please explain the nature of your medical condition and why you need an air conditioner: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I understand that this is a medical request for air conditioning based on a true medical need or disability. All requests will be reviewed on a case-by-case basis. A completed request and documentation of a need for air conditioning does not guarantee that your request will be approved. Falsification of this form will result in University Disciplinary actions.

Signature: ____________________________________________________________________
AUTHORIZATION TO RECEIVE INFORMATION

I authorize Saint Peter's University to receive information from the professional who fills out the Medical Request for Air Conditioning form, and for him/her to discuss my condition(s) with Health Services Staff if necessary.

Student Name (printed): ________________________________

Student Signature: ___________________________________ Date: __________________

Physician completes this section:

The responding physician must be currently treating you. The responding physician must be one of the following: Primary Care Physician, Allergist, Pulmonologist or Ear, Nose and Throat Physician.

Your patient (listed above) has requested the use of an air conditioner in their University Residence Hall room. Saint Peter's University has limited ability to permit air conditioners however; we do our best to accommodate individuals who have a medical condition that warrants the need for an air conditioner. Please assist us in determining how great your patient's need for use of an air conditioner is by providing the following information:

1. What is the nature of the patient's condition? Please provide as much detail as possible so we can have a better understanding of your patient's condition.

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. Is the condition intermittent or seasonal in nature? ___ Yes ___ No If Yes, when and how often is your patient affected?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. What is the expected duration of the condition? ___ Weeks ___ Months ___ Permanent ___ Other

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. Is there any other relevant medical information of which we should be aware? (Attach additional sheet if necessary)

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3
Physician’s Name (please print)

Physician’s Signature

Physician’s Office Phone #

Health Services & Residence Life completes this section:

OFFICE USE ONLY:

Date Received __________________________
Reviewed By ____________________________
Approved ______ Not Approved ______

Reason ________________________________________________
_____________________________________________________
_____________________________________________________